AUTHORIZATION FOR DISCLOSURE OF PROTECTED DENTAL RECORDS

212 S 4th St Suite 200
Grand Forks, ND 58201
Clinic Phone (701) 757-2100
Records Phone (701) 757-2810
Records Fax (701) 757-2811
Records@SpectraHealth.org

Name: _____ Date Of Birth: _____

Street Address: _____ Phone Number: 1 _____

City: _____ State: _____ Zip: _____

Email: _____ Other Name(s): _____

THIS AUTHORIZES SPECTRA HEALTH DENTAL CLINC TO

_____
Name of Dental Clinic/Care Facility/Other

(CHOOSE **ONE** OPTION)

☐ **RELEASE RECORDS TO:**

OR

☐ **OBTAIN RECORDS FROM:**

_____
Street Address

_____ _____ _____
City State Zip

1 _____ 1 _____
Phone Fax

_____
Email **(required for releasing radiography)**

INFORMATION TO BE DISCLOSED (mark **X** in all boxes that apply)

☐ Current Radiography **(must list email above)**	☐ Dental Health Status	☐ Diagnostic Casts
☐ Health History	☐ Prescription Records	☐ Treatment Record & Dental Charts
☐ Photos	☐ Other: _____	

I understand that if the person(s) and/or organization(s) listed about are not a health care provider, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of the authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Spectra Health Clinical Records Department at (701) 757-2810.

Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw This Authorization - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Spectra Health Clinical Records Department at (701) 757-2810. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good for one year from the date signed, unless otherwise specified here _____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature_____ Date_____ Relationship to Patient_____

If signed by other than patient, state relationship and authority to do so.